TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
MARSHFIELD CLINIC

Respondent Name
ACE AMERICAN INSURANCE COMPANY

MFDR Tracking Number
M4-17-2619-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
May 5, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Since this is a workers compensation hearing loss claim, Marshfield Clinic is prevented from billing the patient for the hearing aids, and ESIS should be required to pay for these whether or not they are a covered benefit for Medicare."

Amount in Dispute: $4,800.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Per the Adjuster's instructions, this service has been denied for Absence of Pre-authorization. Enclosed you will find a copy of the original Explanation of Review."

Response Submitted by: ESIS Bill Review

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
May 27, 2016	V5260 (Hearing Aids)	$4,800.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 sets out the medical reimbursement guidelines.
3. 28 Texas Administrative Code §134.203 sets out the sets out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
4. Texas Labor Code §413.011 sets out the reimbursement policies and guidelines; treatment guidelines and protocols.
5. Texas Labor Code §408.021 sets out the entitlement to medical benefits.

6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:

   EOB dated June 28, 2016

   - 1 – Items, codes and services that are no covered by Medicare
   - 2 – P12 – Workers compensation jurisdictional fee schedule adjustment

   EOB dated November 1, 2016

   - 1 – Previous gross recommended payment amount on line: $0;
   - 2 – Items, codes and services that are no covered by Medicare
   - 3 – 193 – Workers compensation jurisdictional fee schedule adjustment
   - 4 – P12 – Workers compensation jurisdictional fee schedule adjustment
   - 5 – This appeal is denied as we find the original review reflected the appropriate allowance for the service rendered. We find that no additional recommendation is warranted at this time

   EOB dated May 18, 2017 – This audit was conducted after the filing of the DWC060 request, MDR received 5/5/17.

   - 2 – This procedure on this date was previously reviewed
   - 4 – 193 – Workers compensation jurisdictional fee schedule adjustment
   - 5 – 197 – Precertification/authorization/notification absent
   - 6 – This appeal is denied as we find the original review reflected the appropriate allowance for the service rendered. We find that no additional recommendation is warranted at this
   - 8 – No proof of pre-auth

Issues

1. Under what authority is the request for medical fee dispute resolution considered?
2. Does the respondent's position statement address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed?
3. What Medicare payment policies apply to disputed HCPCS Code V5260?
4. Did the requestor submit documentation to support a fair and reasonable reimbursement for HCPCS Code V5260?

Findings

1. The requestor is a health care provider that rendered disputed services in the state of Wisconsin to an injured employee with an existing Texas Workers' Compensation claim. The health care provider was dissatisfied with the insurance carrier's final action. The health care provider requested reconsideration from the insurance carrier and was denied payment after reconsideration. The health care provider has requested medical fee dispute resolution under 28 Texas Administrative Code §133.307. Because the requestor has sought the administrative remedy outlined in 28 Texas Administrative Code §133.307 for resolution of the matter of the request for additional payment, the Division concludes that it has jurisdiction to decide the issues in this dispute pursuant to the Texas Workers' Compensation Act and applicable rules.

2. The requestor seeks reimbursement for HCPCS code V5260 rendered on May 27, 2016. The insurance carrier denied/reduced the disputed services with denial/reduction code(s) indicated above. The insurance carrier conducted an audit of the disputed services after the filing of the medical fee dispute request. The audit was conducted by the insurance carrier on May 18, 2017 and the medical fee dispute request was received by MDR on May 5, 2017. The division finds the following:

   28 Texas Administrative Code §133.307(d)(2)(F) states that " The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review."

   The respondent raised issues of preauthorization after the filing of the MDR as reflected in the EOB with an audit date of May 18, 2017. The additional claim adjustment codes and denial reasons do not match the explanation of benefits submitted by the requestor. The respondent did not submit sufficient information to MFDR to support that the submitted review analysis had ever been presented to the requestor or that the requestor had otherwise been informed of these new denial reasons or defenses prior to the date that the request for medical fee dispute resolution was filed with the Division; therefore, the Division concludes that the respondent has waived the right to raise such additional denial reasons or defenses. Any newly raised denial reasons or defenses shall not be considered in this review. The division will proceed with the review and address the denial reasons presented to the requestor prior to the filing of the medical fee dispute resolution request (DWC060).

3. 28 Texas Administrative Code §134.203 states in pertinent part, "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules..."

   The AMA CPT Code Book defines HCPCS Code V5260 as "Hearing aid, digital, binaural, ITE."

   The division finds the Medicare payment policies indicates that procedure code V5260, has status indicator N, denoting a non-covered service no payment allowable is identified by Medicare, as Medicare does not pay for this code. However, pursuant to Section §408.021 (a) (1-3), "An employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to health care that: (1) Cures or relieves the effects naturally resulting from the compensable injury: (2) promotes recovery; or (3) enhances the ability of the employee to return to or retain employment." The disputed services are therefore reviewed pursuant to the applicable rules and guidelines for determine reimbursement for HCPCS Code V5260.

4. The requestor seeks reimbursement for a HCPCS code not valued by Medicare (HCPCS Code V5260). Per Texas Administrative Code §134.203 "(f) For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement)."

   This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1, effective March 1, 2008, 33 *Texas Register* 626, which requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection 134.1(f), which states that "Fair and reasonable reimbursement shall: (1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available."

   Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines."

   28 Texas Administrative Code §133.307(c)(2)(O), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable." Review of the submitted documentation finds that:

- The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
- The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.
- Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for reimbursement is not supported. Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. As a result, the division cannot recommended reimbursement for the disputed service.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		June 23, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.